FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040428

Facility Name: MAPLEWOOD CARE

Address: 50 NORTH JANE DRIVE (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

Telephone Number: (847) 697-3750 **Fax #** (847) 697-5385

IDPA ID Number: 363868385001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,495	1,140	1,156	20,791	8
9	SNF/PED					9
10	ICF	43,155	2,660	524	46,339	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,650	3,800	1,680	67,130	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.60%

D. How many bed-hold days during this year were paid by Public Aid?
166 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 931

Medicare Intermediary AdminaStar - Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	211,169	21,267	33,912	266,348		266,348	(20,631)	245,717			1
2	Food Purchase		288,818		288,818	(29,434)	259,384	(163)	259,222			2
3	Housekeeping	187,014	27,432		214,446		214,446	699	215,145			3
4	Laundry	42,366	31,977		74,343		74,343		74,343			4
5	Heat and Other Utilities			135,302	135,302		135,302	2,195	137,497			5
6	Maintenance	59,197	28,851	69,847	157,895		157,895	(22,781)	135,114			6
7	Other (specify):*							4,034	4,034			7
8	**TOTAL General Services**	499,746	398,345	239,061	1,137,152	(29,434)	1,107,718	(36,647)	1,071,072			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,332,270	103,309	878,544	2,314,123		2,314,123	(20,234)	2,293,889			10
10a	Therapy	151,058		4,367	155,425		155,425		155,425			10a
11	Activities	101,965	20,321	2,472	124,758		124,758		124,758			11
12	Social Services	155,451		5,930	161,381		161,381		161,381			12
13	Nurse Aide Training			1,268	1,268		1,268		1,268			13
14	Program Transportation			1,266	1,266		1,266		1,266			14
15	Other (specify):*							3,721	3,721			15
16	**TOTAL Health Care and Programs**	1,740,744	123,630	899,847	2,764,221		2,764,221	(16,513)	2,747,708			16
	C. General Administration											
17	Administrative	59,757		75,552	135,309		135,309	25,248	160,557			17
18	Directors Fees											18
19	Professional Services			185,534	185,534		185,534	(110,934)	74,600			19
20	Dues, Fees, Subscriptions & Promotions			44,877	44,877		44,877	(18,831)	26,046			20
21	Clerical & General Office Expenses	104,848	23,614	85,772	214,234		214,234	5,110	219,344			21
22	Employee Benefits & Payroll Taxes			331,100	331,100	29,434	360,534	(7,108)	353,426			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,744	2,744		2,744	208	2,952			24
25	Other Admin. Staff Transportation			3,799	3,799		3,799	1,943	5,742			25
26	Insurance-Prop.Liab.Malpractice			89,269	89,269		89,269	1,146	90,415			26
27	Other (specify):*							30,824	30,824			27
28	**TOTAL General Administration**	164,605	23,614	818,647	1,006,866	29,434	1,036,300	(72,394)	963,906			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,405,095	545,589	1,957,555	4,908,239		4,908,239	(125,554)	4,782,685			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAPLEWOOD CARE #0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			147,480	147,480		147,480	276,174	423,654			30
31	Amortization of Pre-Op. & Org.							6,667	6,667			31
32	Interest			113,984	113,984		113,984	1,100,486	1,214,470			32
33	Real Estate Taxes			89,813	89,813		89,813	4,644	94,457			33
34	Rent-Facility & Grounds			1,140,661	1,140,661		1,140,661	(1,140,661)				34
35	Rent-Equipment & Vehicles			10,978	10,978		10,978	7,908	18,886			35
36	Other (specify):*							9,920	9,920			36
37	**TOTAL Ownership**			1,502,916	1,502,916		1,502,916	265,138	1,768,054			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,772	51,332	86,104		86,104		86,104			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		34,772	162,475	197,247		197,247		197,247			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,405,095	580,361	3,622,946	6,608,402		6,608,402	139,584	6,747,986			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,507)	30		9
10	Interest and Other Investment Income	(30,531)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(586)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,363)	21		24
25	Fund Raising, Advertising and Promotional	(9,983)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,816)	20		28
29	Other-Attach Schedule	(100,867)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (222,816)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	362,400		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 362,400		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 139,584		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MAPLEWOOD CARE

ID# 0040428

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COLLECTIONS	$ (312)	19	1
2	TRUST FEES	(150)	20	2
3	NON ALLOWABLE EMPLOYEE BENEFITS	(7,108)	22	3
4	LATE FEE - BUILDING	(50,261)	20	4
5	NON ALLOWABLE TRAVEL	(1,898)	25	5
6	CAPITALIZED R&M	(9,765)	6	6
7	NOT ALLOWABLE LEGAL	(27,589)	19	7
8	JURY DUTY	(17)	10	8
9	IL COUNCIL (COPE)	(3,567)	20	9
10	OUT OF PERIOD SEMINAR	(200)	24	10
11				11
12				12
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(20,631)							(20,631)	1
2	Food Purchase	(163)											(163)	2
3	Housekeeping			699									699	3
4	Laundry													4
5	Heat and Other Utilities			843	1,352								2,195	5
6	Maintenance	(9,765)		625	(11,641)	(2,000)							(22,781)	6
7	Other (specify):*				734	3,300							4,034	7
8	**TOTAL General Services**	(9,928)		2,167	(9,555)	(19,331)							(36,647)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)			(20,217)								(20,234)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,721								3,721	15
16	**TOTAL Health Care and Programs**	(17)			(16,496)								(16,513)	16
	C. General Administration													
17	Administrative			16,101	(62,983)	67,768		4,362					25,248	17
18	Directors Fees													18
19	Professional Services	(27,901)		(87,629)	(9,198)	13,775		19					(110,934)	19
20	Fees, Subscriptions & Promotions	(69,363)	50,261	82	177			12					(18,831)	20
21	Clerical & General Office Expenses	(53,363)		51,073	7,382			18					5,110	21
22	Employee Benefits & Payroll Taxes	(7,108)											(7,108)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(200)		118	290								208	24
25	Other Admin. Staff Transportation	(1,898)		661	3,180								1,943	25
26	Insurance-Prop.Liab.Malpractice			436	673			37					1,146	26
27	Other (specify):*			9,318	8,703	12,289		514					30,824	27
28	**TOTAL General Administration**	(159,833)	50,261	(9,840)	(51,776)	93,832		4,962					(72,394)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(169,778)	50,261	(7,673)	(77,827)	74,501		4,962					(125,554)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(22,507)	292,141	2,588	3,952								276,174	30
31	Amortization of Pre-Op. & Org.		6,667										6,667	31
32	Interest	(30,531)	1,126,187	1,148	3,682								1,100,486	32
33	Real Estate Taxes			1,575	3,069								4,644	33
34	Rent-Facility & Grounds		(1,140,661)										(1,140,661)	34
35	Rent-Equipment & Vehicles			2,679	4,937			292					7,908	35
36	Other (specify):*		9,920										9,920	36
37	**TOTAL Ownership**	(53,038)	294,254	7,990	15,640			292					265,138	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(222,816)	344,515	317	(62,187)	74,501		5,254					139,584	45

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		
				MAPLEWOOD, LLC.		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 1,140,661	MAPLEWOOD, LLC.	100.00%	$	$ (1,140,661)	1
2	V	32	INTEREST EXPENSE		MAPLEWOOD, LLC.	100.00%	1,126,187	1,126,187	2
3	V	30	DEPRECIATION		MAPLEWOOD, LLC.	100.00%	292,141	292,141	3
4	V	31	AMORTIZATION		MAPLEWOOD, LLC.	100.00%	6,667	6,667	4
5	V	36	ASSIGNMENT FEE EXPENSE		MAPLEWOOD, LLC.	100.00%	9,920	9,920	5
6	V	20	LATE FEE EXPENSE		MAPLEWOOD, LLC.	100.00%	50,261	50,261	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,140,661			$ 1,485,176	$ * 344,515	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 699	$ 699	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	843	843	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	625	625	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,101	16,101	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,829	1,829	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	82	82	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	51,073	51,073	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	118	118	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	661	661	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	436	436	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,318	9,318	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,588	2,588	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,148	1,148	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,575	1,575	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,679	2,679	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	89,458	PREFERRED BOOKKEEPING	100.00%		(89,458)	32
33	V	19	COMPUTER	4,875	PREFERRED BOOKKEEPING	100.00%	4,875		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 94,333			$ 94,650	$ * 317	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,352	$ 1,352	15
16	V	6	REPAIRS AND MAINT.	18,276	S.I.R. MANAGEMENT, INC.	100.00%	6,635	(11,641)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	734	734	17
18	V	10	NURSING	40,200	S.I.R. MANAGEMENT, INC.	100.00%	19,983	(20,217)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,721	3,721	19
20	V	17	ADMINISTRATIVE	71,232	S.I.R. MANAGEMENT, INC.	100.00%	8,249	(62,983)	20
21	V	19	PROFESSIONAL FEES	16,440	S.I.R. MANAGEMENT, INC.	100.00%	7,242	(9,198)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	177	177	22
23	V	21	CLERICAL & GENERAL	20,712	S.I.R. MANAGEMENT, INC.	100.00%	28,094	7,382	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	290	290	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,180	3,180	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	673	673	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,703	8,703	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,952	3,952	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,682	3,682	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,069	3,069	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,937	4,937	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 166,860			$ 104,673	$ * (62,187)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 20,712	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,841	$ (14,871)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,099	1,099	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	67,768	67,768	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,775	13,775	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,289	12,289	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	5,832	S.I.R. MANAGEMENT, INC.	100.00%	3,832	(2,000)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	748	748	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	7,440	(5,760)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,453	1,453	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 39,744			$ 114,245	$ * 74,501	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 122,136	$ 122,136	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	122,136	CCS EMPLOYEE BENEFIT GROUP	100.00%		(122,136)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 122,136			$ 122,136	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 19	$ 19	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	18	18	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	37	37	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	292	292	19
20	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	8,714	8,714	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	514	514	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	(32)	(32)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 9,574	$ * 5,254	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Owner	Administrative	25.74%	See Attached	4.27	9.49%	Alloc Sal	$ 17,803	17-7	1
2	Mike Giannini	Owner	Administrative	20.81%	See Attached	4.27	9.49%	Alloc Sal/Fees	17,923	17-7	2
3	Louise Bergthold	Owner	Administrative	5.91%	See Attached	5.87	10.67%	Alloc Sal	19,678	17-7	3
4	Joey Abramchik	Owner	Administrative	2.46%	See Attached	5.33	10.66%	Alloc Fees	13,775	17-7	4
5	Tom Winter	Owner	Administrative	0.74%	See Attached	6.21	10.35%	Alloc Sal	16,101	17-7	5
6	Stuart Sikes	Owner	Administrative	0.99%	See Attached	4.27	10.68%	Alloc Fees	11,580	17-7	6
7	Jeff Oravec	Owner	Administrative	0.49%	See Attached	4.27	10.68%	Alloc Sal	7,856	17-7	7
8	Arturo Rominiquit	Relative	Clerical	0	See Attached	4.14	10.35%	Alloc Sal	2,346	21-7	8
9	Nenita Guzman	Relative	Dietary	0	See Attached	5.33	10.66%	Alloc Sal	5,841	1-7	9
10	Eric Rothner	Relative	Administrative	0.00	See Attached	0.67	0.93%	Alloc Sal	1,642	17-7	10
11	Bill Brotzman	Owner	Administrative	2.96%	0	40	100.00%	Admin Sal	59,757	17-1	11
12											12
13								TOTAL	$ 174,302		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	$ 6,745	$	89,458	$ 699	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		89,458	843	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		89,458	625	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	89,458	16,101	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		89,458	1,829	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		89,458	82	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	89,458	51,073	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		89,458	118	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		89,458	661	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		89,458	436	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		89,458	9,318	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		89,458	2,588	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		89,458	1,148	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		89,458	1,575	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		89,458	2,679	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,875	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 94,650	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	67,130	$ 1,352	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	67,130	6,635	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		67,130	734	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	67,130	19,983	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		67,130	3,721	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	67,130	8,249	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		67,130	7,242	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		67,130	177	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	67,130	28,094	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		67,130	290	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		67,130	3,180	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		67,130	673	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		67,130	8,703	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		67,130	3,952	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		67,130	3,682	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		67,130	3,069	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		67,130	4,937	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 104,673	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	67,130	$ 5,841	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		67,130	1,099	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	67,130	67,768	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		67,130	13,775	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	$ 115,229	$	67,130	$ 12,289	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 11,413	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	5,832	3,832	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	5,832	$ 748	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	13,200	7,440	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		13,200	1,453	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 114,245	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 122,136	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 122,136	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 430	$	4,320	$ 19	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		4,320	18	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		4,320	37	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		4,320	292	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			4,320		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	4	8,714	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		4	514	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)			(32)	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 9,574	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	SIR MANAGEMENT	X		WORKING CAPITAL				1,530,000			78,473	6
7	CIB BANK		X	WORKING CAPITAL				400,489			34,045	7
8											1,466	8
9	TOTAL Facility Related						$	$ 1,930,489			$ 113,984	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										1,100,486	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,100,486	14
15	TOTALS (line 9+line14)						$	$ 1,930,489			$ 1,214,470	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC MAPLEWOOD,LLC	X					$	$			$ 1,126,187	1
2	ALLOC PREF. BOOKPNG	X									1,148	2
3	ALLOC SIR MANAGEMENT	X									3,682	3
4	INTEREST INCOME										(30,531)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,100,486	21

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	88,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	91,907	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,707	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	90,750	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	94,457	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	79,660	8
	1997	79,254	9
	1998	80,608	10
	1999	85,194	11
	2000	87,263	12

2001 ACCRUAL = 2000 EXPENSE 87263.46 * 1.04 = 90750

TOTAL 2001 TAXES PAID = MAPLEWOOD CARE $87263 + ALLOC PREF. BOOKKPNG $1575 + ALLOC SIR MGT $3069 = $91907

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLEWOOD CARE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040428

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06 - 15 - 304 - 015	Long Term Care	$ 87,263.46	$ 87,263.46
2.	SEE ATTACHED	SEE ATTACHED	$ 64,023.09	$ 4,776.52
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 151,286.55	$ 92,039.98

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,780 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 6,667 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1993	$ 517,253	1
2					2
3	TOTALS			$ 517,253	3

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	98,204		20	3,593	3,593	33,384	9
10	Various			1994	13,684		20	684	684	5,734	10
11	Various			1995	5,179		20	259	259	1,674	11
12	Various			1996	19,800		20	990	(990)	5,775	12
13	Various			1997	21,688		20	1,085	1,085	5,260	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		9,914,284	255,201		284,203	29,002	2,725,001	68
69	Financial Statement Depreciation			147,480			(147,480)		69
70	TOTAL (lines 4 thru 69)		$ 10,072,839	$ 402,681		$ 290,814	$ (113,847)	$ 2,776,828	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,072,839	$ 402,681		$ 290,814	$ (111,867)	$ 2,776,828	1
2	ROOM DIVIDERS	1998	5,674		20	284	284	876	2
3	ROOF DRAINS	1998	2,100		20	105	105	368	3
4	DRAPES	1998	2,572		20	129	129	441	4
5	DRAPES	1998	1,370		20	69	69	236	5
6	PAINTING	1998	878		20	44	44	147	6
7	HOT WATER HEATER	1998	2,679		20	134	134	424	7
8	HEATING & COOLING	1998	1,100		20	55	55	170	8
9	BUILDNG EXHAUST FANS	1998	1,204		20	60	60	185	9
10	WATER CONDITIONER	1998	1,500		20	75	75	288	10
11	HOT WATER HEATER	1999	1,132		20				11
12	HVAC WORK	1999	542		20				12
13	FIRE DOOR	1999	1,494		20				13
14	HOT WATER HEATER	1999	4,778		20	239	239	697	14
15	HVAC WORK	1999	7,410		20	371	371	1,051	15
16	REMODELING	1999	11,357		20	568	568	1,278	16
17	HVAC ROOFTOP	1999	9,070		20	454	454	984	17
18	HVAC ROOFTOP	1999	3,076		20	154	154	334	18
19	HVAC WORK	1999	2,035		20	102	102	238	19
20	HVAC WORK	1999	1,693		20	85	85	198	20
21	HVAC WORK	1999	2,405		20	120	120	270	21
22	FLOORING	1999	1,364		20	68	68	142	22
23	WALK IN REPAIR	1999	672		20	34	34	34	23
24	FLOORING	2000	60,142		20	3,007	3,007	5,763	24
25	PAINTING	2000	36,067		20	1,803	1,803	3,456	25
26	FLOORING	2000	18,304		20	915	915	1,678	26
27	PAINTING	2000	14,885		20	744	744	1,364	27
28	FLOORING	2000	31,252		20	1,563	1,563	2,866	28
29	PASS ELEVATOR	2000	34,890		20	1,745	1,745	3,199	29
30	PAINTING	2000	40,751		20	2,038	2,038	3,736	30
31	PAINTING	2000	21,202		20	1,060	1,060	2,120	31
32	PAINTING	2000	46,688		20	2,334	2,334	4,668	32
33	PAINTING	2000	33,775		20	1,689	1,689	3,378	33
34	TOTAL (lines 1 thru 33)		$ 10,476,900	$ 402,681		$ 310,862	$ (91,819)	$ 2,817,417	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,476,900	$ 402,681		$ 310,862	$ (91,819)	$ 2,817,417	1
2	CARPETING	2000	1,000		20	50	50	88	2
3	FLOORING	2000	31,716		20	1,586	1,586	2,776	3
4	FLOORING	2000	18,304		20	915	915	1,601	4
5	NURSE STATION	2000	17,728		20	886	886	1,551	5
6	ROOM DIVIDERS	2000	35,870		20	1,794	1,794	3,140	6
7	PAINTING	2000	14,259		20	713	713	1,188	7
8	CARPETING	2000	3,163		20	158	158	263	8
9	FLOORING	2000	4,210		20	211	211	334	9
10	FIRE DAYERS	2000	45,200		20	2,260	2,260	3,390	10
11	HVAC SLEEVE	2000	1,367		20	68	68	108	11
12	WINDOW TREATMENTS	2000	2,499		20	125	125	198	12
13	NURSE STATION FURN	2000	9,502		20	475	475	910	13
14	RESIDENT FURN	2000	13,289		20	664	664	1,217	14
15	WINDOW TREATMENTS	2000	26,479		20	1,324	1,324	2,207	15
16	GAS & ELECTRIC	2000	1,452		20	73	73	79	16
17	THERMOSTAT	2000	1,088		20	54	54	104	17
18	WATER HEATER	2001	10,761		20	493	493	493	18
19	ELEVATOR WORK	2001	13,900		20	579	579	579	19
20	FLOORING	2001	14,489		20	966	966	966	20
21	HVAC WORK	2001	9,400		20	274	274	274	21
22	ELECTRICAL WORK	2001	13,800		20	288	288	288	22
23	ELECTRICAL WORK	2001	6,100		20	25	25	25	23
24	CONDENSING UNIT	2001	1,840		20	31	31	31	24
25	HEAT EXCHANGER	2001	1,633		20	68	68	68	25
26	HOT WATER HEATER	2001	1,142		20	43	43	43	26
27	DRAIN WORK	2001	2,400		20	80	80	80	27
28	PAINTING	2001	690		20	20	20	20	28
29	PAINTING	2001	522		20	9	9	9	29
30	DUCTWORK	2001	1,084		20	32	32	32	30
31	HVAC	2001	1,187		20	15	15	15	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,782,974	$ 402,681		$ 325,141	$ (77,540)	$ 2,839,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	203		1993		$ 9,827,799	$ 251,995	35	$ 280,794	$ 28,799	$ 2,702,643	4
5	SIR		1993		28,499	905	35	814	(91)	6,921	5
6	SIR		1993		14,624	464	35	418	(46)	3,551	6
7											7
8											8
	Improvement Type**										
9	SIR PROPERTIES-PREFERRED BOOKKEEPING			1999	1,853	185	20	93	(92)	232	9
10	SIR PROPERTIES-PREFERRED BOOKKEEPING			1998	886	89	20	44	(45)	155	10
11	SIR PROPERTIES-PREFERRED BOOKKEEPING			1997	55	6	20	3	(3)	15	11
12	SIR PROPERTIES-PREFERRED BOOKKEEPING			1994	139	4	20	7	(3)	52	12
13	SIR PROPERTIES-PREFERRED BOOKKEEPING			1993	237	7	20	12	5	101	13
14	SIR PROPERTIES - SIR MANAGEMENT			1999	3,611	361	20	181	(180)	451	14
15	SIR PROPERTIES - SIR MANAGEMENT			1998	1,726	173	20	86	(87)	302	15
16	SIR PROPERTIES - SIR MANAGEMENT			1997	107	11	20	5	(6)	30	16
17	SIR PROPERTIES - SIR MANAGEMENT			1994	271	7	20	14	7	102	17
18	SIR PROPERTIES - SIR MANAGEMENT			1993	462	13	20	23	10	197	18
19	PREFERRED BOOKKEEPING			1997	18,263	409	20	913	504	4,391	19
20	PREFERRED BOOKKEEPING			1999	145	28	20	7	(21)	18	20
21	PREFERRED BOOKKEEPING			2000	916		20	46	46	65	21
22	SIR MANAGEMENT, INC.			1993	12,240	341	20	618	277	5,442	22
23	SIR MANAGEMENT, INC.			1994	38		20	4	4	28	23
24	SIR MANAGEMENT, INC.			1995	280		20	14	14	90	24
25	SIR MANAGEMENT, INC.			1999	1,330	63	20	67	4	147	25
26	SIR MANAGEMENT, INC.			2000	803	140	20	40	(100)	68	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,914,284	$ 255,201		$ 284,203	$ 28,996	$ 2,725,001	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 978,256	$ 43,343	$ 97,636	$ 54,293	10	$ 645,653	71
72	Current Year Purchases	16,946	137	877	740	10	877	72
73	Fully Depreciated Assets	121,705				10	121,705	73
74								74
75	TOTALS	$ 1,116,907	$ 43,480	$ 98,513	$ 55,033		$ 768,235	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,417,134	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 446,161	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 423,654	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,507)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,607,729	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☒ X NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 5,765 Description: DISH MACHINE-$1356, ICE MACHINE-$1800, COPIER-$2609
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevy G10 Van	$ 433	$ 5,213	17
18	ALLOC PREF. BOOKPNG			2,679	18
19	ALLOC SIR MGT			4,937	19
20	ALLOC ECM OWNERS COUNCIL			292	20
21	TOTAL		$ 433	$ 13,121	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,268	$	$ 1,268
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,268	$	$ 1,268
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,268			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 21,164	$		$ 21,164	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,267			1,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			28,096			28,096	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				19,555		19,555	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					805	15,217		16,022	13
14	TOTAL			$		$ 51,332	$ 34,772		$ 86,104	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,057	$ 12,157	1
2	Cash-Patient Deposits	29,806	29,806	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,384,307	1,384,307	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	15,889	15,889	6
7	Other Prepaid Expenses	780	75,187	7
8	Accounts Receivable (owners or related parties)	20,300	20,300	8
9	Other(specify): See supplemental schedule	88,051	108,351	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,551,190	$ 1,648,037	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		517,253	13
14	Buildings, at Historical Cost		9,827,799	14
15	Leasehold Improvements, at Historical Cost	570,241	570,241	15
16	Equipment, at Historical Cost	703,438	1,312,438	16
17	Accumulated Depreciation (book methods)	(526,590)	(3,015,053)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		49,997	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	487,200	487,200	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,234,289	$ 9,749,875	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,785,479	$ 11,397,912	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 208,975	$ 208,974	26
27	Officer's Accounts Payable		20,300	27
28	Accounts Payable-Patient Deposits	33,861	33,861	28
29	Short-Term Notes Payable	1,695,000	1,695,000	29
30	Accrued Salaries Payable	187,165	187,165	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,105	11,105	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,750	90,750	32
33	Accrued Interest Payable	2,206	2,206	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,000	6,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	88,530	11,829,168	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,323,592	$ 14,084,529	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	235,489	235,489	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 235,489	$ 235,489	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,559,081	$ 14,320,018	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 226,398	$ (2,922,106)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,785,479	$ 11,397,912	48

*(See instructions.)

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 460,609	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 460,609	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(234,211)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (234,211)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 226,398	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,303,081	1
2	Discounts and Allowances for all Levels	(143,406)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,159,675	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	132,016	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 132,016	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,849	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	516	19
20	Radiology and X-Ray		20
21	Other Medical Services	19,587	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,952	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,531	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,531	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	17	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,374,191	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,137,152	31
32	Health Care	2,764,221	32
33	General Administration	1,006,866	33
	B. Capital Expense		
34	Ownership	1,502,916	34
	C. Ancillary Expense		
35	Special Cost Centers	86,104	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,608,402	40
41	**Income before Income Taxes (line 30 minus line 40)****	(234,211)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (234,211)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,725	2,152	$ 66,795	$ 31.04	1
2	Assistant Director of Nursing	433	458	10,842	23.67	2
3	Registered Nurses	23,912	26,023	552,962	21.25	3
4	Licensed Practical Nurses	6,397	7,067	126,550	17.91	4
5	Nurse Aides & Orderlies	48,614	50,640	505,386	9.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,602	15,071	151,058	10.02	8
9	Activity Director					9
10	Activity Assistants	8,442	8,794	101,965	11.59	10
11	Social Service Workers	13,505	14,679	155,451	10.59	11
12	Dietician					12
13	Food Service Supervisor	1,843	2,086	40,216	19.28	13
14	Head Cook	4,300	4,603	37,815	8.22	14
15	Cook Helpers/Assistants	19,251	20,251	133,138	6.57	15
16	Dishwashers					16
17	Maintenance Workers	4,181	4,354	59,197	13.60	17
18	Housekeepers	25,363	26,898	187,014	6.95	18
19	Laundry	6,054	6,378	42,366	6.64	19
20	Administrator	1,833	2,086	59,757	28.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,553	7,931	104,848	13.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,909	4,299	69,735	16.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,917	203,770	$ 2,405,095 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 13,200	01-03	35
36	Medical Director	MONTHLY	6,000	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	MONTHLY	40,200	10-03	38
39	Pharmacist Consultant	36	1,800	10-03	39
40	Physical Therapy Consultant	MONTHLY	2,678	10a-03	40
41	Occupational Therapy Consultant	MONTHLY	1,650	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	39	10a-03	43
44	Activity Consultant	52	2,472	11-03	44
45	Social Service Consultant	70	3,794	12-03	45
46	Other(specify)				46
47	PSYCHO SOCIAL	45	2,136	12-03	47
48	DIR OF FOOD SERVICE	MONTHLY	20,712	01-03	48
49	TOTAL (lines 35 - 48)	300	$ 98,713		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,690	$ 263,818	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	26,953	568,694	10-03	52
53	TOTAL (lines 50 - 52)	32,643	$ 832,512		53

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BILL BROTZMAN	ADMINISTRATOR	2.96	$ 59,757
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,757

B. Administrative - Other

Description	Amount
DIRECTOR OF ADMINISTRATIVE SERVICES-SIR MGT.	$ 25,584
ANCILLARY ADMINISTRATIVE CHARGES- SIR MGT.	45,648
ECM OWNERS COUNCIL - MANAGEMENT FEE	4,320
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 75,552

C. Professional Services

Vendor/Payee	Type	Amount
PREFERRED BOOKKEEPING	ACCOUNTING	$ 21,250
FR&R	ACCOUNTING	21,063
PREFERRED BOOKKEEPING	COMPUTER SERVICES	4,872
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	1,130
MID AMERICA PROGRAMMING	MDS SOFTWARE	1,320
SEE ATTACHED SCHEDULE	LEGAL	50,939
SIR MANAGEMENT	DIR. OF REG. SERVICES	16,440
PREFERRED BOOKKEEPING	BOOKKEEPING SERV.	68,208
STUART SIKES	COLLECTIONS (ADJ p. 5)	312
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 185,534

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,087
Unemployment Compensation Insurance	15,426
FICA Taxes	180,567
Employee Health Insurance	83,663
Employee Meals	29,434
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTION	5,898
EMPLOYEE BENEFTS	7,351
TOTAL (agree to Schedule V, line 22, col.8)	$ 353,426

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	18,422
Health Care Worker Background Check (Indicate # of checks performed 186)	1,303
ADVERTISING	9,983
DUES,SUBSCRIPTIONS AND LICENSES	9,217
YELLOW PAGES	4,816
ALLOC ECM OWNERS COUNCIL	12
ALLOC PREF. BOOKKEEPING	82
ALLOC SIR MGT.	177
Less: Public Relations Expense	(9,983)
Non-allowable advertising	
Yellow page advertising	(4,816)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,613

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,544
ALLOC PREFERRED BOOKKEEPING	118
ALLOC SIR MANAGEMENT	290
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,952

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
9													
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12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MAPLEWOOD CARE # 0040428 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL $7,870

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,911 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? X YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 111,143
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 29,434 Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees